
The model law fusing incapacity and mental health legislation – a comment on the forensic aspects of the proposal

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1. The Proposal Described

The proposal by Szmukler and others for a law that fuses mental health law and mental capacity law in England and Wales, both in the context of civil admissions to hospital based on the mental disorder of the patient and the making of orders by the criminal courts, can be summarised in the following quotes from their paper. They suggest

“a legal regime that ... relies squarely on the incapacity of the person to make necessary treatment decisions as the primary justification for intervention in their life.”

By intervention is meant both detention and treatment under compulsion: so, rather than separate criteria for detention (based on the risk of harm) and treatment (based on capacity, at least in part), there would be a single incapacity test

“that specifies the conditions for both treatment under compulsion and treatment under circumstances amounting to a ‘deprivation of liberty’.”

What is meant by ‘incapacity’? It is an

“inability to understand, recall, process, use or weigh relevant information; inability to communicate a decision; or inability to reach a decision that is sufficiently stable for it to be followed.”

There would be a requirement that there be no less restrictive option available than intervention; for emergency situations, there would also be a safeguard for intervention based on a reasonable belief as to a lack of capacity.

This scheme would not preclude involuntary treatment aimed at protecting others, which may be a central concern in the forensic context. The proponents note that

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“involuntary treatment for the protection of others ... is permitted ... first, where treatment for the protection of others is in the patient’s best interests, and second, where in the course of providing treatment in the best interests of the patient, there arises a risk of harm to others.”

The authors accept that the involvement in their proposed regime of those who are formally ‘forensic’ patients because they are in the criminal justice system has to take into account the fact that there are different categories of patient, namely those on remand awaiting trial, serving prisoners who have been convicted, and also some who have been found not guilty by reason of insanity or found unfit to stand trial but to have committed the actus reus of the offence and have been detained. A further complication identified is that some patients involved in the criminal justice system will be subject to an underlying prison sentence and so can be returned to prison if treatment is no longer possible because the individual regains capacity and declines to accept further treatment, whereas others might be detainable only in hospital for treatment. If lack of capacity were an essential pre-requisite to the lawfulness of detention, then those in this latter category would have to be released if they did not agree to remain in hospital. This, the authors note, “is an outcome that may not be politically or socially acceptable if the person concerned is deemed to still present a serious risk of harm”. It also points, they say, to a further important principle, namely the need to protect other people from serious harm, which must be relevant in the forensic field.

However, the authors suggest that the pure incapacity principles should be compromised only in narrowly defined circumstances. Some groups could be treated without any modification of the basic principles: mentally-disordered offenders with capacity could be held in a suitable facility for treatment with their consent whilst their sentences continued to run; and offenders without capacity could be treated in the same way as non-offenders without capacity. So serving prisoners who needed treatment could be transferred to hospital if they lacked capacity or if they had capacity and consented. Although the authors propose that the courts could impose a compulsory treatment order without a concurrent prison sentence, which would have the same effect as a civil order, they also note that mentally disordered offenders convicted of a serious offence could be sentenced to imprisonment and then transferred to hospital if they were without capacity or if they consented.

They point to only one group in respect of whom a different approach would be necessary as they are not subject to a prison sentence, namely those found not guilty by reason of insanity or unfit to stand trial but to have committed the actus reus of the offence. Although people in this group without capacity could be treated on that basis, the authors would allow treatment even if there was capacity and no consent if a serious mental impairment or disturbance had contributed significantly to the conduct (the actus reus of a serious offence) and effective treatment could be offered that could be expected to reduce the risk of recurrence.

The proposals are accompanied by a draft bill: the parts relevant to the forensic setting are as follows. (i) Those charged with a criminal offence may be sent to hospital for a medical report or treatment (if the aim cannot be achieved by bail conditions): but this must be based on the person’s consent if he or she has capacity or the best interests of the person if he or she does not have capacity (which would be subject to review by a Mental Capacity Tribunal). (ii) Those convicted of offences could be made subject to a hospital order alone or with a concurrent criminal sentence. The hospital order would have the same effect as a civil compulsory treatment order (which may be on a community or in-patient basis, and may include treatment if it is in the care plan on the basis of which the order is made), and so would cease to operate if the criteria no longer applied, including the recovery of capacity: if there was a concurrent

criminal sentence that had not expired at that stage, the patient could be placed in prison if they did not need further treatment or did not consent to it. The proposal does not contain any equivalent of the current regime allowing the imposition of a restriction order². (iii) Prisoners needing treatment can be transferred to hospital if there is either consent or lack of capacity and transfer is in the best interests of the person. (iv) For those found not guilty by reason of insanity or unfit to stand trial, detention in hospital can be based on the best interests of the person if he or she lacks capacity or to protect other persons if the person has capacity, the impairment or dysfunction of mind contributed to the offending behaviour and treatment would be likely to reduce the risk of the behaviour recurring. An alternative would be possible, namely the making of compulsory treatment order, giving them the equivalent status to a civil patient.

2. Commentary

(i) The Legislative Context

New legislation has been adopted recently, or significant amendments have been made to existing legislation, in Ireland, Scotland and England and Wales; there is a process of reform ongoing in Northern Ireland. There are some significant differences in approach as to the role of capacity in determining whether a patient should be detained. In Scotland, civil detention requires a finding that the patient's mental disorder leads to a significant impairment in the making of decisions about treatment in addition to other criteria based on the risk posed³; it seems that the Northern Ireland Assembly will have proposals put to it that a similar test be adopted there⁴. In Ireland, the *Mental Health Act 2001* has impaired capacity as an alternative to a risk of serious harm test as a basis for civil detention⁵. However, there is no role for impaired capacity in the test for detention in England and Wales, attempts to adopt the Scottish approach having been rejected during the passage of what became the *Mental Health Act 2007*⁶.

Even where capacity is part of the test for civil detention, it is not a feature for those who are placed in hospital via the criminal justice system. So impaired capacity is not a feature of criminal orders in the amended regime in Scotland, the main concern expressed being that a person in front of a criminal court who was willing to accept treatment would be deprived of it if a capacity test was in place⁷: a pragmatic need to ensure that treatment was available was felt more important. Equally, in Ireland, prisoners may

2 and so the dual key of the consent of the Secretary of State for transfer and leave, and the different regime as to release (see ss41 and 73 *Mental Health Act 1983*) would cease to operate.

3 Section 64 of the *Mental Health (Care and Treatment) (Scotland) Act 2003*.

4 The Bamford Review – see <http://www.rmhl.dni.gov.uk/index.htm> (last accessed 29 August 2009) – suggested that mental health law and capacity law be fused; the Northern Ireland Executive has indicated that it plans to introduce two bills at the same time to update or replace the *Mental Health (Northern Ireland) Order 1986* and also introduce capacity legislation – see “Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland”, www.dhsspsni.gov.uk/legislative-framework-for-mental-capacity.pdf (last accessed 19 October 2009)

5 Section 3 of the Act, in the definition of what amounts to “mental disorder”.

6 The process leading to the 2007 Act started with the Expert Committee appointed to advise the Secretary of State for Health on the *Mental Health Act 1983* for England and Wales (also known as the Richardson Committee), which reported in November 1999. Its report – available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009576 (last accessed 29 August 2009) – included an indication that it supported the view of the majority of respondents to it that protection of the public was a valid reason for over-riding capacitated decisions to refuse treatment in the civil context (and so it would have supported an arrangement such as that in place in Ireland).

7 Paragraph 191 of the Scottish Executive's Policy Memorandum accompanying the *Mental Health (Scotland) Bill* (SP Bill 64), 16 September 2002, available at <http://www.scottish.parliament.uk/business/bills/billsnotInProgress/index.htm#64> (last accessed 29 August 2009)

be transferred to hospital against their consent if two doctors indicate that treatment is not available in the prison setting⁸: this no doubt reflects a similar pragmatic approach. In England and Wales, in relation to the forensic setting, the Richardson Committee – which provided the initial impetus for reform – had not reached final conclusions: although it was more cautious about allowing criminal justice patients to be in hospital without either agreement and cooperation or lack of capacity, this was premised on the basis that most of those who caused problems would be personality disordered and could be made subject to a prison sentence with the prospect of transfer to prison if they did not succeed in hospital. But given the legislators' concerns about capacity in the civil context, using public and patient safety as the key feature, the absence of any reference to capacity in the formal forensic setting is not surprising. As for Northern Ireland, the Bamford Committee indicated that its proposal for linking mental health law and capacity law would require further thought as to how that linked with the criminal justice setting⁹: it remains to be seen what will be the outcome of this process.

What is apparent from this brief review of the legislative context is that it will be difficult for the authors of the proposal to persuade legislators that the approach they suggest should be adopted in the forensic setting. This is, of course, a matter of pragmatic concern: there are also issues that are more matters of principle.

(ii) Discrimination and Public Safety

The underlying premise of the proposal to place impaired capacity at the centre of the criteria for detention, whether in a forensic or non-forensic setting, is that there should be an equivalence of treatment on account of mental disorder and physical disorder: just as doctors cannot treat without consent those who do not take sensible advice to deal with a physical ailment, so they should not be able to treat those with a psychiatric ailment who chose not to accept treatment if that choice is a true choice. Putting words into the mouths of Szmukler and others, the response to those who raise their eyebrows at this suggestion on the ground of risk to the public would be two-fold: there is, first, the point that mental disorder is not particularly associated with risks to others¹⁰; and, secondly, there is the ethical point of non-discrimination, namely that it is wrong to have a different regime in place on account of a mental disorder¹¹, given that the criminal law is there to deal with risks to others from those who cannot be helped by the hospital system because they have capacity but chose not to accept assistance.

But how far does this non-discrimination point go? In the first place, it may assume too much in relation to the absence of powers to treat physical disorders without consent when there is capacity. In fact, there are well-established bases for preventive detention based on the risk of harm to others arising from physical disorders. Article 5 of the European Convention, which authorises the lawful detention of "persons of unsound mind" in Art 5(1)(e), also allows detention to prevent the spread of infectious

8 Section 15 of the Criminal Law (Insanity) Act 2006

9 "A Comprehensive Legislative Framework", paras 5.5. and 5.6

10 The Bamford Committee, for example, at paras 5.58–5.59 of its Comprehensive Legislative Framework report (cited above) noted that "The vast majority of people with mental illness are no more likely than anyone else to commit a violent crime. ... The greatest risk of harm ... is to themselves. Nevertheless, there is a modest link between mental illness and violence, particularly in some individuals who are currently experiencing symptoms of severe mental illness, not using effective medication and abusing alcohol and/or drugs. In such cases violence can

be a reflection of insufficient treatment and support services." It also noted research as to the raised risk of violence from those with some forms of personality disorder.

11 A pejorative version of the same idea is that doctors have enough to cope with in dealing with patients who do take advice: the additional effort of dealing with patients who are not willing to cooperate is not something that should be forced upon them. This is not necessarily a viewpoint that is selfish: the therapeutic environment, and hence the assistance that can be provided to other patients, is compromised by having to deal with recalcitrant patients, and the proper place for them is another setting – which can be prison if detention is necessary.

diseases. Consistently with this provision, the *Public Health (Control of Disease) Act 1984* creates a list of notifiable diseases (s10) and a justice of the peace may order the detention of a person with a notifiable disease to prevent the spreading of infection (s38)¹². Since passing on such a disease with a criminal mens rea would be a criminal offence¹³, the criminal law is also available in that situation, as is tort law: but prevention is permitted by the law in England and Wales, including the preventive detention of recalcitrant patients with capacity.

Whilst avoiding any crass comparison between mental disorder and a serious infectious disease, there can be little doubt that the 1984 statute reflects a principle that it is ethical to provide for compulsory steps against those who present a danger to others from a medical condition: whilst it is important to undermine any prejudiced view that mental disorder is to be equated with danger to the public, it must also be accepted that there are a number of instances where such a risk does arise. The key is to ensure that the proportionality of the intervention is maintained as between a physical illness that might pose a risk to others and mental disorder that might pose a similar problem.

Also worthy of mention in this context is another part of Art 5(1)(e), the detention of “alcoholics”. In *Litwa v Poland*¹⁴, the European Court of Human Rights concluded that the term covered not just those addicted to alcohol but also those who were intoxicated: the reason for this broad interpretation was that Art 5(1)(e) was a provision designed to allow detention of those whose condition might cause dangers to themselves or to others¹⁵. The Court then found a breach of Art 5 on the basis that there had been no consideration of the proportionality of detention on the facts, which was in a sobering-up centre, rather than an alternative course permitted by domestic law such as taking Mr Litwa home¹⁶. Again, the important question is the proportionality of taking preventive action.

Another area of public safety law is relevant. The European Court of Human Rights has made it clear that the criminal law and its deterrent effect might not always be sufficient to protect against assault by others. The right to life in Art 2 requires specific preventive action when the authorities know or ought to have known of an identifiable danger to life: see *Osman v UK*¹⁷. This clearly applies when the risk arises from the mental disorder of an individual, as a breach of Art 2 was found when a mentally-ill prisoner killed his cell-mate following an inadequate assessment of the risk he posed: see *Edwards v UK*¹⁸.

12 It is a criminal offence to breach an order; and the court may order return to hospital. There is no provision for compulsory treatment, so the common law principles allowing only treatment in the best interests of those with capacity apply.

13 See, eg, *R v Dica* [2004] 2 CrAppR 2, [2004] QB 1257 – infecting someone with HIV could amount to the offence of inflicting grievous bodily harm contrary to s20 Offences Against the Person Act 1861.

14 [2000] Mental Health Law Reports 226, (2001) 33 EHRR 53

15 See para 60: “The Court observes that the word “alcoholics”, in its common usage, denotes persons who are addicted to alcohol. On the other hand, in Art 5§1 of the Convention this term is found in a context that includes a reference to several other categories of individuals, that is, persons spreading infectious diseases, persons of unsound mind, drug addicts and vagrants. There is a link between all those persons in that they may be deprived of their

liberty either in order to be given medical treatment or because of considerations dictated by social policy, or on both medical and social grounds. It is therefore legitimate to conclude from this context that a predominant reason why the Convention allows the persons mentioned in para 1(e) of Art 5 to be deprived of their liberty is not only that they are dangerous for public safety but also that their own interests may necessitate their detention (see *Guzzardi v Italy* (1980) 3 EHRR 333, §98 in fine).”

16 Paras 65ff.

17 (2000) 29 EHRR 245, [2000] Inquest Law Reports 101: the Court did not find a breach on the facts. The same principle has been applied to dangerous municipal activities, namely the operation of a rubbish dump, where a breach was found: see *Oneriyildiz v Turkey* (2005) 41 EHRR 20, [2004] Inquest Law Reports 108.

18 [2002] Mental Health Law Reports 220, (2002) 35 EHRR 19.

It also extends to self-harming behaviour¹⁹. And Article 3, the duty to avoid inhuman or degrading treatment, might also be engaged by failing to prevent an assault or failing to prevent someone acting out self-harming behaviour: so in *Keenan v UK*²⁰, the European Court found that the suicide of a mentally-ill prisoner did not breach Art 2 because it has not been possible to identify the specific risk to life, but did breach Art 3 because it revealed a lack of effective monitoring.

Again it is necessary not to overplay the connection between mental disorder and harm: but the well-established point that protecting people from themselves may be necessary cannot be ignored, nor can the fact that protecting people from others is also a duty of the state in certain circumstances, the duty extending beyond merely having a criminal justice system in place. Once these points are recognised, there is nothing inherently discriminatory about making mental disorder the feature on the basis of which preventive action is taken: what is needed is the existence of an appropriate level of risk, whatever the basis for the intervention, so as to avoid any intervention being disproportionate; and an equivalence of risk in different settings so as to avoid discrimination. This approach does, it has to be said, favour the line taken by the government during the debates on the *Mental Health Act 2007* that intervention is a question of risk rather than capacity. It may be that those Parliamentarians who concentrated on an assertion that it was discriminatory not to include the question of capacity missed what was the real argument, namely ensuring that there was no discrimination by applying a lesser test for detention on the ground of mental disorder than in relation to other risk-based grounds for detention²¹.

In summary, the proposal to make the absence of capacity a central feature to all detention based on mental disorder, which rests on the basis that the absence of cooperation from patients with capacity can be left to the criminal law and the prison system, goes too far. The police-power basis for detention on the ground of mental disorder, both as regards harm to others and self-harm, is well-established and necessary under human rights law. Szmukler and others do accept that capacity principles can be amended to permit detention for those who do not have the safety net (from the public safety perspective) of a prison sentence, namely the group found not guilty by reason of insanity or to be unfit to stand trial but to have committed the *actus reus* of an offence: but these two exceptions still require a criminal action to have occurred, whereas public safety/police-power considerations allow and in some circumstances mandate an earlier intervention, based on the degree of the risk presented. So the authors of the fusion proposal, it is suggested, need to supply further arguments as to how the proposal can withstand this legitimate demand of public safety. In short, why should it not be a test of proportionality of intervention – such as a requirement that detention be necessary to avoid a serious risk to others – irrespective of capacity and consent (or as a long-stop if there is capacity and consent)?

(iii) Other Human Rights Arguments

There is at least one further human rights-based argument to which Szmukler and others need to respond in the forensic context, where doctors may have to have recalcitrant patients in their hospitals.

19 The common law had already accepted that there was a duty to prevent suicide: see *Reeves v Commissioner of Police* [2000] 1 AC 360; for a recent instance of this in a mental health context and making use of Art 2 because negligence was not available on the facts, see *Savage v South Essex Partnership NHS Foundation Trust* [2009] 2 WLR 115.

20 [2001] Prison Law Reports 180, (2001) 33 EHRR 38

21 Capacity does not feature as a part of the criteria for the

lawfulness of detention on the basis of unsoundness of mind under Art 5(1)(e): see, as the classic example, *Winterwerp v Netherlands* (1979) 2 EHRR 387. See also *Megyeri v Germany* (1993) 15 EHRR 584: the failure to put in place special procedural protections may breach Art 5(4) if a mentally disordered person is incapable of representing himself: this again does not seem to require a lack of capacity to act but rather a reduced ability to look after one's interests.

In addition to the fact that protective detention is possible, including detention based on social welfare grounds²², it is well-established that detention based on mental disorder must be in a suitable clinical setting. The example of this is *Aerts v Belgium*²³: he was detained in a prison psychiatric wing following a finding that he had committed an assault but was not responsible in light of his psychiatric condition. The detention was supposed to be merely short-term, whilst a place was found in a clinic, but it extended for several months: this was found to breach Art 5(1)(e) because detention on the ground of mental disorder has to be in an appropriate therapeutic setting. Although Mr Aerts might have been found to lack capacity had such a test been applied to him – and indeed the Court rejected an argument that his detention could be viewed as being under Art 5(1)(a) because the finding of the domestic court negated the possibility of arguing that he was criminally convicted – the principle set out in the case does not seem to be limited to those who are without capacity or who wish to seek treatment²⁴. This case supports the viewpoint that considerations such as the better availability of treatment in a clinical setting, and hence the prospect of assistance, are of importance in assessing the arbitrariness or otherwise of detention. Of course, under the fusion proposal, treatment will be available: however, it will depend on consent or lack of capacity to consent. Accordingly, the authors will have to explain why it is less arbitrary to detain a mentally disordered person with capacity in a non-therapeutic environment rather than to abide by the person's decision not to accept treatment and so – certainly if release rests on any prospect of treatment being provided and being successful – warehousing them in this non-therapeutic setting.

(iv) Another Pragmatic Argument

Although it is no doubt true that the presence of mental disorder that does not deprive a person of capacity does not extinguish criminal responsibility in the context of our view of responsibility arising from a choice to breach the law (or at least to engage in conduct that is defined as criminal, even if this is not known by the criminal defendant), the criminal process involved in applying this substantive law allows more shades of grey to be taken into account: it does not insist that conduct be viewed in the black and white terms of asking whether there is or is not criminal responsibility. A key part of the nuance is the discretion of the prosecutor as to whether or not to proceed with a criminal prosecution. For England and Wales, this is codified in the Code for Crown Prosecutors²⁵, and basically provides that a prosecution conducted by the Crown Prosecution Service should not proceed unless there is both a realistic prospect of conviction (an evidential sufficiency test) and also that there is a public interest in prosecuting²⁶. The availability of alternatives to prosecution, of which diversion into the mental health system may be one, is a feature of the public interest that might militate against taking a prosecution. So, if a person has capacity but is nevertheless affected by mental disorder, the availability of civil detention justified by the risk posed to others, as evidenced by the conduct leading to the police intervention²⁷, may be a way to secure what would be considered a just solution, given that the responsibility retained by the accused is nevertheless diminished by reason of mental disorder. Szmukler and others need to explain further why it

22 See *Litwa v Poland*, above n14.

23 (2000) 29 EHRR 50

24 See n21 above: capacity is not part of the Convention test for the lawfulness of detention.

25 The 2004 Code is available at www.cps.gov.uk/Publications/docs/code2004english.pdf (last accessed 29 August 2009)

26 The availability of the public interest test is long-established: see para 5.6 of the Code, quoting the 1951

statement of the then Attorney-General, Lord Shawcross, that "It has never been the rule in this country – I hope it never will be – that suspected criminal offences must automatically be the subject of prosecution."

27 This may arise from a specific report of a crime, or the police coming across a situation that allows them to take action under s136 Mental Health Act 1983, which will often involve conduct that could lead to an arrest and the criminal process being instigated.

would be to the benefit of both the individuals affected and society as a whole to reduce the circumstances in which a prosecutor can take a view that a prosecution is not necessary because the public interest is served by diversion from the criminal justice system.

3. Conclusion

The reduction of discrimination and prejudice faced by mentally-disordered persons is of great importance. Respect for autonomy and non-discrimination are key features of a civilised society. A principled approach to mental health law that puts autonomy in the sense of capacity at the centre is to be commended in this regard because it emphasises that mental disorder ought not to be treated differently to physical disorder. However, it cannot hide the fact that there is another important basis for society to take action, namely the need to reduce harm: the importance of autonomy limits the right to prevent freely-chosen self-harm, but the need to intervene clearly applies in the forensic setting, namely in relation to harm caused by one person to another. This need may mandate action of a preventive nature, not merely responding to a past misdeed. If this need arises from the mental disorder of the person against whom action is taken, the fact that the risk posed arises from mental disorder is not by itself discriminatory so long as the test for intervention involves a risk of a similar magnitude as would allow intervention when there was a cause for the risk other than mental disorder. In addition, a focus on capacity as the filter for all intervention when mental disorder is in issue would deprive the legal system of the flexibility of making use of a hospital disposal when that is the just response to the situation, and possibly force prosecuting authorities to make use of the formal criminal justice system and force courts to condemn people to detention in inappropriate and non-therapeutic settings. The authors of the fusion proposal may be able to bring arguments to bear to suggest that the balance is still in favour of a capacity-based system: this review is aimed to provide merely a reminder that there are some other factors that ought to be addressed before starting in earnest on the task of persuading policy makers and legislators, who have been less than receptive in recent times to making capacity central to the forensic aspects of mental health law.